REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

The Connecticut Association of Optometrists would defer to the planners on this issue. However, it seems that the larger the pool, the more the risk is shared.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

We would suggest a joint approach, again, mainly to facilitate the creation of larger pools of enrollees.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

CAO would support permitting businesses with up to 100 employees to use the exchange in 2014.

4. Should Connecticut seek to expand access to businesses with more than 100SS0 employees in 2017, with HHS approval? YES

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

CAO would support hybrid approach—we would like to stay away from a one size fits all approach.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange? NO

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

We would suggest that linkages be created with proven and reliable stop-loss carriers.

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

We believe it is vital that consumers are educated and aware of all of their options. For eye care services, they need to understand the role of the Optometrist in the broader health care system.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

CAO believes their role should be viewed in context with the regulations being developed on medical-loss ratios.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

The state should add additional requirements on qualified health plans in the exchange beyond what is listed in the ACA as it relates to the provider network. Specifically, the state should ensure that the network adequacy requirements are meaningful enough to ensure that there are enough providers of all types to meet the needs of beneficiaries in the exchange. The state should require that the adequacy requirements not only spell out the number of credentialed providers are in each plan, type of provider and geographical distribution of those providers. This information should be publically available and the exchange operating entity should permit public scrutiny of this information and solicit opinions from the public and interested parties to ensure that the provider distribution meets the needs of the beneficiaries.

Additionally, the state should actively monitor the plan's compliance with Section 1201 in Title I of the ACA is crucial to providing quality, affordable health care for all Americans participating in the state health insurance exchanges. Section 1201 amends the Public Health Service Act to require, among other patient protections, that plans not discriminate among health care professionals based solely on their professional degrees. The law prohibits a group health plan or an issuer offering group or individual health insurance coverage from discriminating, with respect to participation under the plan or coverage, against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This provision increases choice and access for patients by preventing plans from arbitrarily eliminating access to licensed practitioners based solely on their professional degree (and not based on their abilities). By increasing the pool of potential network participants, these non-discrimination provisions provide patients with more choices, increase market competition among providers, and incentivize all practitioners to further improve the quality and cost of the services they provide. This should be included in the measures for network adequacy.

Network adequacy is an essential component for any plan that wishes to serve this market and must be included as a requirement for plan certification. Further, network adequacy needs to be defined in a way that assures that patients have access to services provided by healthcare providers like optometrists by requiring plans in the exchange to include optometry as a full participant in the provider network and be included in any method established to determine network adequacy. This will ensure patients are able to access their eye care professionals and create a ready and willing supply of professionals who are ready to provide needed eye and vision care to this newly covered population.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

While the CAO does not take an official position on whether the state should establish a Basic Health Program if the state does, the program participants should have access to a full vision and eye health benefit which would cover not only comprehensive vision and eye healthcare but include a benefit that would cover either eyeglasses or contacts. The population that the Basic Health Program would target (adults at 133% to 200% of the Federal Poverty Level (FPL) and legally residing immigrants below 133% of FPL) will need to have a benefit package that mirrors not only what Medicaid offers but also closely mirrors private insurance in the state in order to help facilitate better utilization of their health insurance and prepare them to be better educated consumers of healthcare. Having a typical benefit package that mirrors private insurance will facilitate the target population to easily move between Medicaid, the Basic Health Program and commercial insurance products with a minimum amount of interruption.

3. How would the Basic Health Program impact other related programs in Connecticut?

If the Basic Health Program does serve as a bridge between Medicaid and private insurance, this will assist the targeted population become better consumers of healthcare by allowing them to fully utilize primary and preventative care benefits, intervening earlier in diseases (which saves the system money) and allowing them to be more productive members of society and driving down costs for the Medicaid and private health insurance markets.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

Not only should the Connecticut exchange utilize a robust web presence and plenty of written material to help educate consumers about the benefits of coverage in the exchange but the state should also develop materials for distribution in healthcare provider offices (waiting room materials). By having healthcare providers who services will potentially be covered by plans in the exchange advertising to patients who may become potential customers will help normalize the exchange to these patients and work to remove any potential stigma associated with insurance exchanges.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

Ideally, if Connecticut decides to have an exchange it should have an operations board advising its policy and this board needs to ensure that providers have a role in the governance structure and have an outlet for the sharing of important participation information of providers participating in an exchange. Having providers at the table will give the exchange leadership an understanding of the issues that patients and providers may be facing with the insurance companies and ideas that the exchange can implement to make the insurance providers more responsive to their needs. Including providers, with groups like consumers, business owners, healthcare advocates who are providing feedback to the exchange will give it important and balanced feedback and create actionable steps that will benefit everybody in the state.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

We believe the network adequacy information we suggested above should be made public and accessible through the exchange website.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

Good question. Perhaps some user fee on those that purchase insurance through the exchange, provided it is nominal.

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

The exchange needs to be user friendly and reputed to be an efficiently administered entity. A minimum of overhead is important to the public's perception that the endeavor is responsible.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

Perhaps Congress could revisit this element and provide better state flexibility.

G. **Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.**

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Let any issuer participate who can meet the requirements.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc/

We would not propose any such limits—let the marketplace decide the issue.

What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

4. Premium collection—none—leave this to the health insurance plans.

5. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage.

The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits